SUBJECT PIHP Network of Service Providers		**CHAPTER** 01	**SECTION** 06	**SUBJECT** 02
CHAPTER Administration	**SECTION** Provider Network			
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I. APPLICATION:

☒ PIHP Board ☒ CMH Providers ☒ SUD Providers
☒ PIHP Staff ☒ CMH Subcontractors

II. POLICY STATEMENT:

It shall be the policy of the Region to ensure a comprehensive network of specialized services and supports is in place which has the capacity to provide services of sufficient amount, scope, and duration to meet the needs of all eligible persons requiring specialty benefit mental health and substance use disorder services.

III. DEFINITIONS:

A. CFR = Code of Federal Regulations – for the purposes of this policy, specifically 42CFR438 – Managed Care

IV. STANDARDS:

A. Network Management Program: The PIHP shall maintain a network management plan (Exhibit A) that delineates the framework of its network management program. The plan shall be updated whenever necessary to reflect current functionality and/or changing rules and regulations imposed upon the PIHP.

B. Network Management Delegation: The PIHP is delegating the management of its local sub-panel of mental health service providers to each CMH and substance use disorders to the Coordinating Agencies (CA). The PIHP shall ensure through its CMH and CA contracts that it remains accountable for any PIHP functions and responsibilities that it delegates to any CMH/CA.

1. Before the delegation, the PIHP shall evaluate the prospective CMHs/CAs ability to perform the activities to be delegated.
2. The PIHP has in writing what specifies the activities and report responsibilities delegated to the CMH or CA.

C. Network Services: The PIHP shall ensure (and each CMH/CA shall assure the PIHP) that all services covered under the state plan, HSW, and additional (B) (3) services listed in the MDCH/PIHP Contract are available and geographically accessible to all beneficiaries of the PIHP.

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D. Network Services - Sufficiency and Availability: The PIHP shall ensure (and each CMH/CA shall assure the PIHP) that a sufficient service delivery network is available, which meets the following requirements:

1. A network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under contract.
2. CMH/CA must have in place a policy that ensures parties that are declined as part of the network are provided written notice of the reason why.
3. The PIHP shall address the following in maintaining and monitoring its provider network:
   a. The anticipated Medicaid enrollment.
   b. The expected utilization of services, taking into consideration the characteristics and healthcare needs of the specified populations in the PIHP's catchment area.
   c. The numbers and types of providers required to furnish the contracted Medicaid services.
   d. The numbers of network providers not accepting new Medicaid referrals; and any capacity limitations that may exist in the network.
   e. The geographic location of providers and Medicaid beneficiaries considering distance, travel, time, the means of transportation, ordinarily used by Medicaid beneficiaries within the region, and whether the location provides physical access to persons with disabilities.
4. The PIHP shall maintain sufficient capacity to provide a "second opinion", as defined in the CFR, from a qualified health care professional within the network, or arranges for the Medicaid beneficiary to obtain one outside the network.
5. Ensure necessary services, covered under the MDCH/PIHP contract are obtained by the CMH/CA, should sufficient capacity not exist within the local network to provide adequate and timely services.
6. Ensure that CMHs/CAs requiring out-of-network services obtain and provide such services at no greater cost to the beneficiary than if services were furnished within the network.
7. The PIHP shall demonstrate that its organizational providers are credentialed as required by CFR §438.214 and the Medicaid Provider Manual.
8. The PIHP shall ensure that each CMH/CA complies with the following requirements:
   a. Timely access. Each CMH/CA must require its providers to meet PIHP standards for timely access to care and services, taking into account the urgency of the need for services.
   b. Ensure the sub-network providers offer hours of operation that are no less than the hours of operation offered to commercial plan enrollees, or comparable Medicaid fee-for-service providers.
9. The PIHP shall establish mechanisms to ensure compliance by the CMHs/CAs and sub-panel providers (i.e. contract monitoring).

E. Network Credentialing: The PIHP shall establish a network-wide uniform credentialing policy.

1. The PIHP and CMHs/CAs shall ensure that each is following a documented process for credentialing and re-credentialing of its direct and contract agency sub-panel providers (organizational and practitioner providers).

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2. The PIHP shall establish uniform provider selection policies and procedures for the provider network. Each CMH/CA shall ensure compliance with these network selection policies, and the development of local procedures on its implementation.
3. The PIHP/CMH and their Provider Networks may not employ or contract with providers excluded or sectioned from participation in Federal Healthcare Programs as verified monthly through both OIG - http://exlusions.oig.hhs.gov AND through the MDHHS sanctioned Provider List -http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_5100-16459--,00.html

F. Provider Registry: CMHs/CA must register with the PIHP any Medicaid state plan, HSW, or additional (B)(3) service it provides directly or through an approved contracted sub-panel provider, as specified in the Medicaid Provider Manual, Mental Health and Substance Abuse Chapter, Section .1.4 CMH must update the provider registry with the PIHP whenever substantial changes occur (e.g. address, scope of program, program additions, program deletions, etc.), according to the format specified by the PIHP. In turn, the PIHP shall be the responsible entity to update the PIHP's provider registry with MDCH.

G. Provider Enrollment: CMHs/CAs must ensure each provider (Organizational and professional practitioner) is enrolled in the PIHP Provider Network database, as required and specified in its provider credentialing policy. Credentialing of network providers must be renewed at least every two years.

H. Special Program Approval:

CMH must obtain PIHP (and MDCH) specific approval for certain programs prior to service delivery and claims submission into to the PIHP, in order to be reported as a Medicaid cost. Programs requiring **special approval** are:

a. Assertive Community Treatment Program
b. Clubhouse Psychosocial Rehabilitation Programs
c. Home-Based Services
d. Crisis Residential Programs
e. Drop-in Programs
f. Intensive Crisis Stabilization

V. PROCEDURES:

PIHP

1. Maintains network management plan for the regional network.

2. Reviews/Updates the PIHP Network Management Plan as necessary.

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3. Annually monitors the overall performance and compliance of each CMH/CA, as required by CFR and MDCH contract, providing a summary report to the PIHP Board on each CMH/CA performance, including any delegated functions.

2. Notifies the MDCH within 7 days of any significant changes to its provider network that affects adequate capacity and services of the network.

VI. EXHIBITS

A. PIHP Provider Network Management Plan

PIHP
Provider Network Management Plan

I. Purpose:

The overall Plan design is a two-tier management model. The overall provider network is coordinated and managed by the PIHP, with the first tier being comprised of those network management functions that will be centrally administrated by the PIHP. The second tier is comprised of those network management functions that the PIHP delegates to qualified provider, which, in-turn, manage a community-based subpanel provider network on behalf of the PIHP.

In combination, the overall network management structure ascertains regulatory compliance, while obtaining management efficiency, effectiveness and systemic integration. In designing the Region 10: Provider Network Management Plan, the following source documents and their corresponding rules, regulations and standards were utilized:

- ✓ CMS: Code of Federal Regulations, especially Section 42 CFR Part 438.
- ✓ MDCH: PIHP Medicaid Contract (including Technical Requirements Attachments)
- ✓ MDCH: Site Review Protocols for PIHPs
- ✓ CARF (Commission on Accreditation of Rehabilitation Facilities) Standards

II. Network Management: Plan Design

The PIHP is the central authority for overall management of the specialty benefit provider network. In this role, the PIHP develops an annual budget and operational plan, and sets common policies, protocols and program monitoring mechanisms for the provider network. To manage its provider network, the PIHP contracts with four (4) Community Mental Healths (CMHs), two (2) Coordinating Agencies (CAs) and possibly other providers directly.

Under this construct, organizational providers that deliver services on a regional basis are under direct contract to the PIHP; while providers that only deliver local services are under contract with the CMHs/CAs as a sub-panel manager. Under this scenario, each CMH/CA manages a local provider panel on behalf of the PIHP.

This PIHP network management responsibility is exercised through its oversight of the four (4) Community Mental Health (CMHs) and two Coordinating Agencies (CAs). The relationship between the PIHP and each CMH/CA is defined by a PIHP/CMH/CA contract agreement. The PIHP/CMH/CA contract agreement specifies the management and service delivery responsibilities of each party.

The underpinning for this contractual relationship is a common organizational culture based in an explicit, common set of values and principles against which the interactions among the organizations and between each organization and its consumers are judged. This document, in turn, specifies the methods by which the PIHP's responsibilities with respect to Network Management for mental health, developmental disability, and substance abuse services and supports in the Thumb Alliance region will be carried out.

The PIHP's Responsibility and Accountability

Within the operational context of the Region 10's network management strategy, the PIHP is accountable to the PIHP Board for developing and maintaining a network of providers for delivering specialized behavioral health services and supports to Medicaid eligible persons in its service area. The global standards to which the PIHP's network must adhere can be summarized as follows*:*

- Provider Sufficiency
  The network has sufficient numbers or providers, range and scope of services, geographic distribution and access to provide effectively for the consumer population (i.e. the capacity to provide each specialty service and support is equal to or greater than the demand for each service and support).

- Provider Specialization
  The network has sufficient numbers of providers that have the specialized skill sets required to meet the medical needs of Medicaid enrollees requiring specialty health care services.

- Reasonable Choice
  The network offers reasonable informed freedom of choice of primary caseholders (e.g. case managers, supports coordinators, clinicians) and specialty practitioners available to the consumer.

- Cultural Competence:
  The network ensures compliance with Limited-English Proficiency, cultural competence, and accommodations of physical and communication limitations.

- Best Value
  The services and delivery system is the best quality possible for the funds available.

- Quality Improvement
  The network has in place mechanisms to continually improve both the overall quality of services provided to its consumers and its own management and administration.

III. Network Management Plan: Scope

This PIHP Network Management Plan identifies functions, issues and goals for activities at the PIHP level. The PIHP is the entity with overall responsibility for ensuring that a system of specialized behavioral health services and supports is available, accessible, and provided within standards of care and available resources to Medicaid eligible persons within the PIHP region. However, operational management of the network of service and

support providers at the local community level has been delegated to the CMHs/CAs. These delegated functions are detailed in the PIHP/CMH/CA contracts as an attachment, Delegation Agreement.

To ensure the PIHP has a sufficient array of available providers, it reviews materials from a variety of sources and obtains input from sources.

IV. PIHP Network Management Functions:

A. Development of the Provider Panel.

- Maintain/contracts through qualified CMH/CA providers. The contract between the PIHP and CMHs/CAs specifying all delegations of any PIHP function to the CMHs/CAs Network, including Network Management Functions.
- Issuing policy and standards for monitoring performance of each CMH/CA.
- Ensuring regional consistency and efficiency with respect to the size and characteristics of local networks. This may be accomplished by conducting a regional capacity analysis.

  The PIHP has a procurement process. The PIHP will issue **"**sole source" service agreements in each county to the local CMH or one (1) of the two (2) CAs that have demonstrated both the expertise needed to properly serve the targeted populations and met the qualifications referenced in the state's Waiver application to participate as PIHP affiliates rather than employ a competitive bid process.

B. Establishment of operating responsibilities and performance expectations for CMHs/CAs.

Operating responsibilities and performance expectations will include:
Commitment to abide by the terms and conditions contained in the PIHP/MDCH contract.
Commitment to abide by the policies, of the PIHP.

- Responsibility to maintain a service provider network which meets MDCH requirements for provision of covered services and which is sufficient in capacity to meet Medicaid requirements for duration, scope and intensity of service.

- Responsibility to meet performance standards established in the MDCH Mission Based Performance Indicator System and those in the PIHP Contract on performance.

- Responsibility to ensure local access to service and to participate in PIHP service authorization management processes.

C. Establishing Funding levels:

The PIHP will fund the network using to a twofold payment methodology approach: Global Budgeting and Shadow Fee for Service system.

- **Global Budgeting and Prepayment Advance:**
  Annually the PIHP will develop an annual budget and program plan for the provider network. In turn, each CMH will submit a proposed budget based on historical experience, modified by known changes in demand for service, and known changes in available Medicaid revenues. The PIHP Board will approve the overall budget for the PIHP. The PIHP will provide a monthly prepayment advance (unearned revenue) to each CMH/CA based upon 1/12 its global budget payment from it MDCH PEPM payment. This prepayment will not be considered "earned income," but will be treated as an advance for local cash flow purposes. It is anticipated that initial Global Budgets will approximate historical service spending levels. It must be noted that the PIHP global budget prepayment methodology is not a 'sub-capitation' model; rather, it is anticipated that historical levels of funding availability will be altered over time as patterns of demand change and consumer severity and service outcome standards are implemented.

- **Cost Settled Service payment methodology.** Each CMH/CA will "earn" its Medicaid revenues by thorough, timely encounter data entry. This earned Medicaid revenue will become a "draw" against the Global Budget prepayment made by the PIHP to each CMH/CA. Under this payment system, the Global budget prepayment of each CMH/CA will be reviewed and adjusted if necessary, based upon "earned revenues," "utilization demands," and "service needs" in the region.

E. PIHP- CMH Responsibility for Managed Care Administrative Functions.
In order to achieve efficiencies in administrative operations, most Administrative Services functions will eventually be centralized and substantially carried out by PIHP staff. Responsibilities of the PIHP and the CMH/CAs are specified in the service agreement, including:

- The PIHP will eventually manage a centralized Access System, including eligibility screenings, determinations and emergency response triage. The PIHP will also maintain 24/7 access, crisis response, and crisis stabilization capacity that includes tie-in to the CMHs/CAs for local system crisis response. CMH/CAs will accept referrals through the Access system in a timely manner, and will actively participate in after-hour crisis response and stabilization services.

- The PIHP will eventually manage a regional Utilization Management system, including development of Practice Guidelines and Service Authorization protocols, authorization of services and Utilization review, and feedback regarding regional utilization trends and issues. CMHs/CAs will continue to authorize as they have; submit authorization data including service denials into the PIHP for UM, UR and Care Management reporting and tracking purposes, and will respond to regional feedback through practice improvements.

- The PIHP will have a de-centralized Provider Network Management system, in accordance with the role responsibilities outlined in the network management plan. Service functions will be performed by the PIHP, while other PNM functions will be delegated to the CMHs/CAs.

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- The PIHP will maintain clinical protocols to be utilized by the provider network. Guidelines will be based upon obtaining effective clinical outcomes, and shall be based upon the most current research and evidence based practices.

- The PIHP will manage a regional Quality Management program, including responsibility for development of the QAPIP and annual QI Plan; and for reporting data to MDCH's performance indicator system and providing feedback to the CMHs/CAs on performance. CMHs/CAs will utilize quality information to improve operations at the local level.

- The PIHP will manage a centralized Financial Management system, including management of regional accounts, a claims adjudication system, centralized audit management and response, management of cash flow to CMHs/CAs, financial reporting to DCH, cost settlement, reinvestment and risk management. CMHs/CAs will pay service providers and provide expenditure and unit/cost reports to the PIHP on a quarterly/semi-annual and annual basis.

- The PIHP will manage a regional Health Information System (HIS)**,** including maintenance of hardware and software for both Managed Care and Practice Management provider reporting and decision support information, provision of management reports for both the PIHP and MDCH, and ensuring that the data collected and reported is accurate and meets HIPAA requirements. Conversely, CMHs/CAs will each manage their local practice management software and the necessary hardware and telecommunication systems necessary to provide required PIHP data and report information in required formats.

- The PIHP will have a de-centralized Customer Services function, including Appeal and Grievance processes and de-centralized production and dissemination of consumer and community information. CMHs/CAs will provide services to consumers which meet specific locally identified consumer needs and which ensure that access to services is supported. Locally, CMHs/CAs will be responsible for informing consumers of provider choice at intake and their right to provider choice on an annual basis.

- The PIHP will manage a Corporate Compliance program for the provider network, including the development of an annual Compliance Plan addressing any areas of improved compliance performance of the provider network.

- The PIHP will develop and maintain a PIHP Website**.** The website will contain all PIHP policies, protocols, procedures, and forms for network providers to obtain access to such materials. The PIHP will update materials on a timely basis. Providers shall be responsible that they are adhering to the most recent policies and protocols.

V. Definition and Delegation of Network Management Functions

In order to achieve and maintain a provider network that meets the managed care administrative requirements of a PIHP, the PIHP, either directly, or through formal delegations to the CMHs/CAs, engages in a number of specific network management functions, including:

1. Network Availability and Capacity Analysis (GAP Analysis)
2. Provider Selection (including Procurement)
3. Credentialing (Provider Organizations and Practitioners)
4. Corporate Compliance
5. Contract & Delegation Management & Monitoring
6. Provider Performance Improvement (Quality Management)
7. Care Coordination and Community Collaboration
8. Customer Services (Enrollee Rights; Provider Choice)

In performing the above PIHP managed care administrative functions, there are certain aspects of these functions that the PIHP has delegated to its CMHs/CAs in accordance with 42 CFR § 438.230. The PIHP is still required to maintain oversight and monitoring of these delegated functions and will complete a pre-delegation evaluation to determine that the agency that performs the delegated functions is capable of doing so. PIHP management oversight of all delegations is accomplished through the PIHP annual delegation evaluation, at the time of its contract monitoring assessment.

The following sections describe, for illustrative purposes, the respective provider network management functions of the PIHP v. CMHs/CAs as it pertains to network management and any functional delegations:

A. Network Availability and Capacity Analysis:

PIHP Network Management Responsibilities:
The PIHP will monitor service needs and provider resourcing capacity. The PIHP will review its own internal processes, to identify and recommend network development and/or procurement needs.

B. Provider Selection:

PIHP Network Management Responsibilities:
The PIHP contracts, consistent with its service selection policy, with CMHs/CAs using the model affiliate service agreement. Any procurement and contracting of local network providers is delegated to the CMHs/CAs.

CMHs/CAs Network Management Responsibilities:
CMHs/CAs provide services directly, or through contract providers. CMHs/CAs utilize their own localized procurement procedures.

C. Credentialing:

PIHP Network Management Responsibilities:
The PIHP establishes the overall credentialing Policy and requirement processes for the entire provider network. The PIHP develops an 'organizational provider enrollment form for the provider network. In this way a common data base of network providers, including their respective credentials, privileges and re-credentialing timeframes are maintained by the PIHP within a common data base. The PIHP is the responsible entity for credentialing the four (4) CMH providers and two (2) CAs, ensuring they meet the core requirements to act as CMHs/CAs, as specified by MDCH. Additionally, the PIHP credentials any organization for which it directly contracts, and all practitioners directly employed by the PIHP.

CMHs/CAs Network Management Responsibilities:
CMHs/CAs must credential their sub-network in compliance with the PIHP's credentialing policy. This includes two types of credentialing: 1) Credential all Organizational providers with whom they subcontract on behalf of the PIHP; and 2) Credential all individual (behavioral health) practitioners within their local network [Note: This latter task may be delegated to an organizational provider, but the CMHs/CAs must ensure PIHP Policy and Standards compliance]. CMH are responsible for enrolling all new organizational providers and practitioner providers into the PIHP data base; and must update the provider enrollment information though a two-year re-credentialing cycle. Failure to enroll new providers and re-credential existing providers in a timely manner may cause billing claims denials and/or contract sanctions.

D. Corporate Compliance:

PIHP Network Management Responsibilities:
The PIHP is the responsible entity to develop a Corporate Compliance Plan. The PIHP maintains a network wide virtual Corporate Compliance Committee and Compliance Officer. On an annual basis, the Compliance Committee reviews the PIHP's Compliance Plan assess goal progress plan and goals as necessary.

E. Contract and Delegation Management & Monitoring:

PIHP Network Management Responsibilities:
The PIHP monitors performance of the CMHs and CAs according to the standards contained in its contract agreements, and PIHP policies. Part of this contract monitoring process includes the monitoring of all delegated administrative managed care functions. Monitoring, including delegation monitoring, occurs via the PIHP's utilization management, care management, credentialing, data management and quality management systems. The PIHP has a single point of responsibility for overseeing contract development with its CMHs; and the PIHP has a single point of contact and responsibility for on-going contract and network development.

CMHs/CAs Network Management Responsibilities:
CMHs/CAs must ensure compliance of their local sub network to the PIHP network management plan, PIHP contract, PIHP policies and federal and state regulations. CMHs/CAs monitor performance of their sub-contracted organizational providers and individual (behavioral health) practitioners according to PIHP requirements. Each CMH/CA must have single point of contact and responsibility for overseeing contract development with its provider network.

F. Quality Management & Performance Improvement:

PIHP Network Management Responsibilities:
The PIHP manages an overall quality management program for the provider network. This includes the development of the Quality Assurance and Performance Improvement Program (QAPIP) for the network; and the development of an annual QI Plan that identifies key performance areas to be improved upon in the network system. The PIHP will develop same structure to act as the oversight body to improve network cost-effectiveness, service delivery quality, and network compliance. This body can be the network's designated body to identify and prioritize systemic improvement areas based upon data management reports, contract compliance reports, MDCH/Federal site reviews, and Accreditation body recommendations. The PIHP also coordinates overall MDCH state reporting and improvement functions of the network.

CMHs/CAs Network Management Responsibilities:
CMHs/CAs develop and manage local QI Plans based upon monitoring and performance reports conducted by the PIHP, MDCH, EQRO and/or CARF.

H. Care Coordination and Community Collaboration

PIHP Network Management Responsibilities:
The PIHP is the responsible entity to develop and maintain Coordination Agreements with all Medicaid Health Plans operating in the region. The PIHP also has a policy on care coordination.

CMH Management Responsibilities:
CMH makes efforts to maintain service coordination agreements with each of the pertinent public and private community-based organizations and providers to address prevalent human conditions and issues that relate to a shared customer base.

VI. Network Management via On-going Monitoring of Operations and Performance

PIHP Network Management and Monitoring Responsibilities

- PIHP quarterly review of its UM data regarding service utilization and trends, obtained from the PIHP Information System.
- PIHP semi-annual review of its UM Plan regarding CMHs and CAs performance regarding clinical protocol compliance and medical record documentation.
- PIHP quarterly review of CMHs/CAs performance on the MDCH MMBPIS with analysis and feedback relative to regional and statewide trends.

- PIHP semi-annual review of its QI Plan performance relative to regional.

- PIHP claims verification reviews (5%) on claims submitted into the PIHP for payment, with claim adjustments as necessary (5% case record reviews, and reviews of those claims against criteria annually prioritized by the PIHP Board).

- PIHP conducts contract reviews to ensure compliance with required elements and delegated functions

- Areas of below target performance will be utilized by the PIHP in its development of its annual:
  - QI Plan
  - UM Plan
  - PIHP/CMH Contract: Performance Indicators & Objectives

Monitoring reports contain statements regarding the expectations of the PIHP regarding specific improvements or areas in which information indicates non-compliance with contractual requirements. Time-frameworks for improvement will be indicated and monitoring to ascertain progress will take place.

Should a provider performance fall below performance expectations, the PIHP utilizes *Corrective Action Plan* processes to achieve timely improvement of the network management performance. Should a provider not improve its compliance of any network management or other administrative managed care delegation, the PIHP reserves the right to revoke the delegation.

CMHs/CAs Network Management and Monitoring Responsibilities:

- CMHs/CAs timely submission of Corrective Action Plans and performance improvement strategies, if any

- CMH/CAs conduct reviews of its Organizational Providers, and having contract and performance improvement reports available for PIHP review.

- CMH/CAs conduct annual monitoring of any administrative sub-delegation to an organizational provider, and having contract and performance improvement reports available for PIHP review.